

## Parental Consent Letter

Date \_\_\_\_\_

Dear Parent/Guardian:

Your child's school has been chosen to take part in the state health department's oral health screening. The purpose of the screening is to gather information on the dental health needs of children throughout Montana.

During the screening, a dentist, dental professional, or trained public health professional will examine your child's teeth to check for tooth decay and other dental problems. Your child will receive an oral health letter informing you about his/her oral health status. This screening, however, does not take the place of regular dental check-ups by your family dentist. Even if you have a family dentist, we encourage you to let your child participate in the screening.

As you know, a healthy mouth is part of total health and wellness and makes a child more ready to learn. By letting your child take part in this dental screening, you will help contribute new information that may benefit all of Montana's children through improved oral health programs. If you have any questions about the oral health screening, please contact Veronica Newhart at (406) 444-0276 or by email at [vnewhart@mt.gov](mailto:vnewhart@mt.gov)

Sincerely,

Name of the oral health person at the school  
Contact information

**Please check the NO or YES box, sign, and return to your child's teacher tomorrow.  
Thank you!**

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Child's Name: \_\_\_\_\_

Child's Teacher: \_\_\_\_\_

\_\_\_\_\_ **YES**, I want my child to receive a dental screening

\_\_\_\_\_ **NO**, I do not want my child to receive a dental screening

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date